Ambulatory Blood Pressure Monitoring

KINGSBRIDGE Private Hospital

Patient number:	
WLI number:	

Referrers are required to complete sections 1-4 accurately and legibly. Inadequately completed forms will not be accepted.

1 - Patient Details

Title:		Forename:		Surname:	
DOB:		Gender: ☐ Male ☐ Female			
Address:					
Post Code:		Tel (Home):		Mobile:	

Patient Identification
For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB. Signed:

Verified by patient: ☐ If another/status: ☐ Signed:

Referring clinician (print name):		Signature		Date	
Address:					
Post Code:		Email :		Mobile	

2 - Clinical Details

Height (cm)	
Weight (kg)	

- ☐ Diuretic
- ☐ Beta Blocker
- ☐ ACE Inhibitor
- ☐ Alpha Blocker
- ☐ Other:

Duration of hypertension:	months

- ☐ Left ventricular heart failure
- ☐ Family history
- ☐ Previous myocardial infraction
- ☐ E.C.G
- ☐ Echocardiogram

Smoker:

- ☐ Non
- ☐ Ex
- ☐ Current/Number per day:

3 - Reason for 24 hour assessment

- ☐ Hypertension
- ☐ Hypotension
- ☐ Other:
- ☐ Poorly controlled
- ☐ White coat response

C.P. (print name)		Signature:	
Date device fitted:		Date device due back:	

Please send completed form by post, fax or email to:
Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com

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AMBULATORY